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Exposure Draft of the Health Care Audit Guide: Changes Accountants Can Expect

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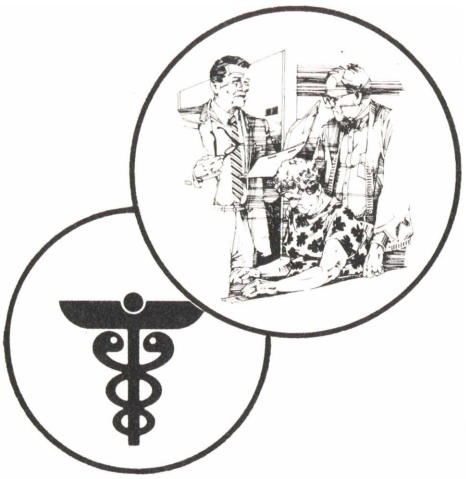

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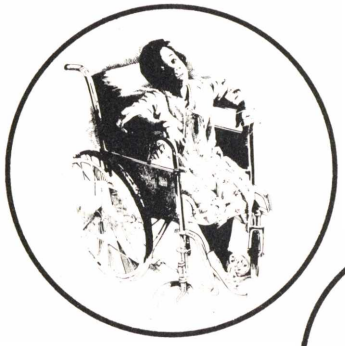

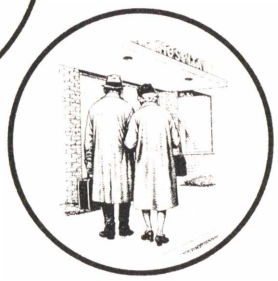

By Sandra Pelfrey and Barbara A. Theisen

Background

Health care and its related costs have received considerable attention during the last two decades. The dramatic improvement in medical technology has caused many institutional health care providers to invest considerable resources in the latest equipment and facilities. While past expansions were typically funded by operations and donations, the cost associated with staying competitive has necessitated that hospitals and other health care providers enter debt markets with increasing regularity. These borrowings have reinforced the need for annual audits. Since 1972, the AICPA *Hospital Audit Guide* has been the primary authoritative literature that describes how transactions unique to hospitals should be recorded and reflected within their financial statements.[1] Although at times inconsistent

or unclear on certain issues, the *Hospital Audit Guide*, along with its related Statements of Position, has provided much needed guidance for an industry that continues to expand.

The process of updating the *Hospital Audit Guide* began in the early 1980s. This task has been complicated by the ongoing evolutionary process in which the health care system operates. For example, services are continually shifting from the inpatient to the outpatient arena. Free-standing ambulatory clinics, physicians' groups and health maintenance organizations (HMO) have increased the competition for patients. Furthermore, federal legislation has pressured hospitals to discharge patients at the earliest possible time or to transfer patients in need of custodial care to skilled nursing facilities to avoid losing payment for services rendered. The number of continuing care retirement communities (CCRC) and skilled nursing facilities has increased to meet the needs of the growing population of elderly citizens who require various levels of nursing care. Finally, malpractice concerns plague many physicians and health care entities. Each factor contributes toward the desirability of increasing the financial reporting and auditing requirements of health care organizations.

A joint committee comprised of the Health Care Committee and the Health Care Audit Guide Task Force of the AICPA has completed an exposure draft (ED) of the Proposed Audit and Accounting Guide entitled "Audits of Providers of Health Care Services." The ED is the initial step in the process of replacing the 1972 *Hospital Audit Guide* and the related Statements of Position (i.e., SOP 78-1, 78-7, 81-2, 85-1 and 87-1) that were included in the 1987 edition of the guide. The final version of the new audit guide for health care providers is expected to be issued this year and is not expected to contain any substantive deviations from the ED.

Accounting Principles

One of the major differences between the ED and the existing guide is the increased scope. The ED provides accounting and auditing guidance for hospitals, clinics and other ambulatory care organizations, HMOs, CCRCs, nursing homes, and home health agencies. This expanded scope reflects the diversification and evolution of health care services over the last seventeen years.

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Apart from institutional differences caused by the nature of services provided, health care entities vary by ownership. The three major classifications of owners include 1) not-for-profit, 2) for-profit, and 3) governmental. The sponsorship or legal structure of a health care entity determines the accounting and financial reporting principles that should be followed. All investor-owned and voluntary not-for-profit health care institutions will follow the accounting and financial reporting guidelines in the new audit guide. Those entities that are part of, or sponsored by, governmental units must seek guidance first from the Governmental Accounting Standards Board (GASB). In the absence of a definitive GASB statement, these institutions will adhere to the principles contained in the audit guide, in addition to any other relevant Financial Accounting Standards Board (FASB) pronouncements.

One of the most interesting aspects of the ED is its emphasis on presenting financial information in a manner consistent with a business enterprise rather than that of a not-for-profit entity. Some examples of this include streamlining the balance sheet to reflect a single fund, reporting "net revenues" on the first line of the statement of revenues and expenses, and reclassifying bad debts as an operating expense. Although display within the statement of revenues and expenses still includes the captions "other operating revenue" and "nonoperating revenue," the current guide's inconsistency regarding donated supplies and donated services has been corrected. The ED classifies both of these items together and displays them under the caption "nonoperating revenue."

The ED also addresses risk-based contracts and their related liabilities by providing that any unrecorded costs associated with such contracts be estimated and accrued as contract services are performed. Any anticipated losses are to be accrued in the first period in which they are considered probable and can be estimated. This change will significantly affect HMOs and other preferred provider organizations as well as their independent auditors.

The ED clarifies the methodology for estimating malpractice claims. It reaffirms the guidelines contained in SOP 87-1 which state that industry experience rates should be used to estimate and record anticipated liabilities from asserted and unasserted claims only if the industry rates are relevant to the entity. If a health care provider's operations and overall risk potential differ significantly from the industry average, the individual entity's experience rate should be used.

The ED identifies the unique accounting transactions and reporting requirements of nonhospital health care providers. Such items include estimating the liability for future services for nursing homes and CCRCs whose residents may have contracts that specify fixed fees and/or fixed incremental rates. Similar liabilities exist for HMOs whose fees may not cover the expected costs of future services.

Finally, the ED provides examples of financial statements for hospitals, nursing homes, CCRCs, home health agencies, HMOs and ambulatory care facilities. These illustrations include cash flow statements and statements of changes in fund balance. The cash flow statement is not in full compliance with SFAS No. 95, "Statement of Cash Flows," since SFAS No. 95 specifically applies to for-profit companies. (An AICPA task force has been formed to analyze SFAS No. 95 to determine its potential impact on the not-for-profit reporting community.)

Auditing

The ED addresses specific auditing concerns common to the health care industry, one of which is the confirmation of patient accounts receivable. Because direct confirmation of patient accounts receivable is often impractical, the ED outlines alternative procedures (e.g., reviewing subsequent payments, reviewing insurance company billings and payments, or examining the patient's medical record) that auditors may use to support accounts receivable balances.

Another auditing concern relates to verifying receivables from third-party insurance carriers. The complexity and variability of third-party reimbursement

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arrangements require auditors to know which and to what extent each reimbursement arrangement is being used by their audit client. Although audit procedures will differ by reimbursement method, one procedure should be a review of the system that assigns patients to specific insurance carriers. Included also should be procedures for reviewing final cost settlement reports for retroactive reimbursement methods or for reviewing methods of determining diagnosis for discharged patients.

Other audit procedures outlined involve the support and proper disclosure of restricted donations and related party transactions, which must be reviewed for compliance, propriety, and fair presentation.

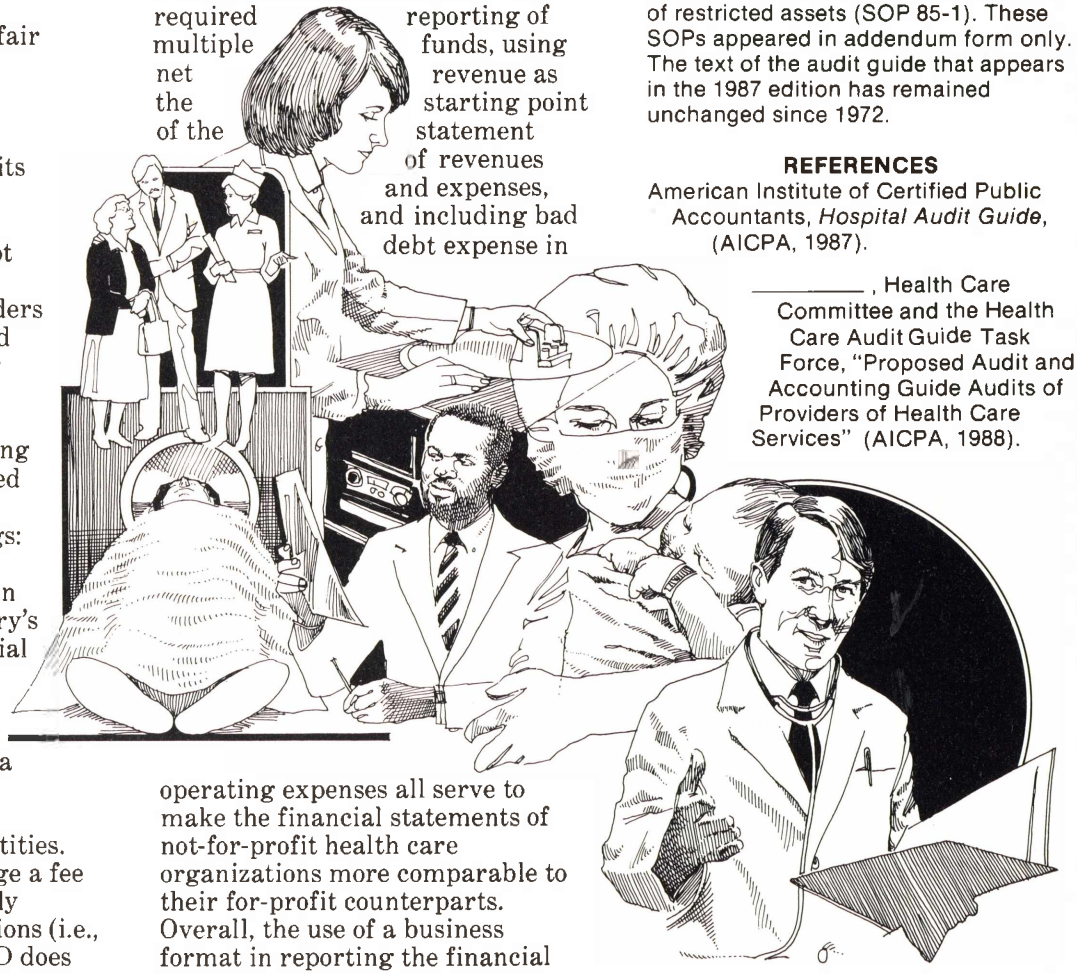
Impact of the ED

The ED not only extends its scope to nonhospital health care providers, but also lends credence to the concept that not-for-profit hospitals and other health care providers are and should be considered businesses. By streamlining the financial statements and formally accepting the generally accepted accounting and reporting principles used by business enterprises, the ED acknowledges two things: 1) the entity's need to make a profit in order to remain in existence, and 2) the industry's need for comparable financial statements regardless of an entity's ownership and/or sponsorship.

There will continue to be a relatively small number of hospitals that can truly be classified as nonbusiness entities. These hospitals do not charge a fee for service and are primarily supported by private donations (i.e., Shriners Hospitals). The ED does not specifically address these nonbusiness entities.

Conclusion

When finalized, the new audit guide will significantly affect the accounting and reporting requirements of most health care entities. Expanding the scope to include nonhospital providers, updating the treatment of revenues and risk-based contracts, and clarifying matters such as the treatment of malpractice loss contingencies provide long-needed guidance. Also significant is the shift in financial statement presentation from a nonbusiness to a business focus. Eliminating the required reporting of multiple funds, using net revenue as the starting point of the statement of revenues and expenses, and including bad debt expense in operating expenses all serve to make the financial statements of not-for-profit health care organizations more comparable to their for-profit counterparts. Overall, the use of a business format in reporting the financial operations of a not-for-profit entity will underscore the reality that health care organizations are, in fact, businesses. Auditors will need to restructure their audits to respond to the changes and to meet the auditing objectives set forth in the ED.



FOOTNOTES

[1]Subsequent editions of the *Hospital Audit Guide* have included Statements of Position (SOP) on topics that affect not-for-profit entities. The SOP topics have included estimating malpractice loss contingencies (SOP 78-10 and 87-1), accounting for marketable equity securities (SOP 78-1), and reporting for tax-exempt debt and funds comprised of restricted assets (SOP 85-1). These SOPs appeared in addendum form only. The text of the audit guide that appears in the 1987 edition has remained unchanged since 1972.

REFERENCES

American Institute of Certified Public Accountants, *Hospital Audit Guide*, (AICPA, 1987).

_____, Health Care Committee and the Health Care Audit Guide Task Force, "Proposed Audit and Accounting Guide Audits of Providers of Health Care Services" (AICPA, 1988).